



## **Case Study of SeniorMetrix Technology: *Adding Efficiencies to Admissions and Readmissions***

### **SITUATION ANALYSIS**

One of the nation's largest managed health care companies recognized that frail and high risk senior patients often were being "warehoused" at Skilled Nursing Facilities (SNF) when their SNF stay was no longer of value. The challenge was to efficiently manage available beds while ensuring quality patient care and progress. The provider wanted assistance for its medical groups' members authorized for SNF admissions to make sure that patients were placed in the proper facility, were receiving the most effective type and level of care, and were being appropriately discharged at the right time to the right setting. One of the provider's medical groups contracted with SeniorMetrix for Post Acute Network Management Services via the company's outcomes predictive tools and post-acute analysis reporting. Outcome predictive tools allow case managers to objectively assess the type, length of stay and anticipated outcome of care for patients who have lost some functional capacity due to illness or injury. Post-acute analysis reporting impartially analyzes the best providers and care management processes using evidence-based, severity-adjusted data.

### **THE SOLUTION**

Closely collaborating with the physician group, SeniorMetrix provided the technology, on-site reviews, assessment tools and tracking reports to enhance numerous operational and cost efficiencies. Hard data, based on hundreds of thousands of actual patient cases, were introduced to the decision-making process for SNF admissions to ensure that patients were being transferred from acute care facilities to the most suitable setting for that patient. Such technology allowed case managers to better determine the timeliness, quality and quantity of care for each patient, as well as expected outcomes in that setting. On-site evaluations by SeniorMetrix were able to bring real comparisons of specific patient populations, as well as improvements in all levels of care. Assessment tools and individual/aggregate tracking reports were initiated to identify gaps in care, mobilize resources and enhance communications among providers, physicians, patients and families. To further strengthen the partnership, weekly rounds, monthly updates on performance measures and ad hoc training of nursing staff were ongoing.

### **RESULTS**

When the partnership between the medical group and SeniorMetrix began in 2001, the provider had 12,900 members. Utilization outcomes showed 66 admissions per 1000 members and 864 SNF days per 1000 members. The average length of stay (ALOS) was 15 days with a 14% gain in functional independence measurement (FIM) upon discharge. During a re-measurement period in 2006, membership was 11,500 members; however, improved utilization results revealed a decrease in both admissions and incurred SNF days per 1,000 members. Specifically, admissions decreased to 57 admissions per 1,000 members and SNF days decreased to 777 days per 1,000 members. The correlating ALOS also declined to 13.5 days per SNF admission. Even with a decrease in SNF inpatient utilization, patients experienced and a 14.9% gain in FIM upon discharge.

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The medical group's results are particularly impressive when compared to data published by CMS for the same time period. According to CMS data for 2006, there were 56 admits per 1000 Medicare members and 1,896 SNF days per 1000 members with an ALOS of 34 days per SNF admission. The 2006 national average SNF reimbursement rate was \$303 per day.

When compared to its ALOS of 13.5 days to the 34-day national average, the contracting group's difference is 19.5 days per admission. At the 2006 national average daily reimbursement rate of \$303, cost savings for that difference is \$5,900 per case. During 2006, there were 658 admissions for the group's population. Using 2006 data, projected savings of \$5,900 per case for those 658 admissions are in the *millions* of dollars. Factoring in administrative costs, reductions in SNF bed days and acute care hospital re-admissions, the net annual Medicare savings is \$3.4 million.

The table below outlines year-to-year trends and outcomes. While utilization and associated costs decreased, functional gain was also measured. During the project period, admission function to SNF declined slightly. As a result, a corresponding and anticipated decrease in discharge function and discharge rate to community settings occurred. It is important to note that these result trends were related to declining function at admission and not to reduction in utilization.

Year	Member Months	Total Admissions	Total # of SNF Days	ALOS	Admits Per 1,000	Days Per 1,000	Admit FIM	Discharge FIM	FIM Gain	Discharge to Community
2000	154,803	410	11,635	28.4	32	936				
2002	152,959	854	11,141	19.0	67	874	68.6	83.0	14.4	77%
2003	121,263	706	10,400	14.7	70	1029	64.8	78.4	13.6	73%
2004	116,232	639	9,072	14.2	66	989	65.2	78.8	13.5	79%
2005	122,789	661	9,347	14.2	65	913	66.6	79.9	13.3	69%
2006	138,000	658	8,938	13.5	57	777	63.8	78.7	14.9	73%
2007	132,228	580	8,034	13.8	53	729	65.0	78.0	16.0	74%

As the managed care market became more widespread, the SNF provider community experienced decreased SNF reimbursement and more aggressive utilization management of skilled services in a rehab facility. Simultaneously, two hospital-based SNF floors closed, all skilled beds in one hospital closed and two community-based SNFs closed in the San Francisco market. Such closings indicate the overall impact of the evolution of managed care.

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For more information about SeniorMetrix ([www.seniormetrix.com](http://www.seniormetrix.com)) and its post-acute care utilization management solutions please contact Mr. Michael T. Sandwith at 615.376.1010 Ext. 360 or [msandwith@seniormetrix.com](mailto:msandwith@seniormetrix.com).